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AUTHOR Paulus, Ellen H.
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ABSTRACT

This practicum was designed to increase the ability of staff to incorporate basic health and safety activities appropriate for preschool children into the curriculum of a program that works with children and families in both center- and home-based settings. The primary goals of the practicum were to increase the number of activities offered and to increase parents' knowledge of appropriate health and safety topics. A curriculum that emphasized health and safety topics was developed, and staff in both settings implemented the curriculum. The resulting lesson plans were compared to those developed before the introduction of the curriculum. A survey was distributed to parents to solicit information about knowledge they might have gained as a result of the implementation of the curriculum. The results of the practicum, which were determined by review and comparison of lesson plan content, were favorable. Lesson plans from both settings showed a distinct increase in the number of health and safety activities included. Results of parent surveys taken in the home-based programs demonstrated a modest increase in knowledge. The information gathered from the parent surveys from center-based programs was inconclusive. Appended are a list of 22 references and other

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Improving Staff Integration of Health and Safety Topics in the Preschool Curriculum

by

Ellen H. Paulus

Cohort 39

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A Practicum Report Presented to the National Master's Program for Child Care Administrators in Partial Fulfillment of the Requirements for the degree of Master of Science

NOVA UNIVERSITY

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I hereby testify that this paper and the work it reports are entirely my own. Where it has been necessary to draw from the work of others, published or unpublished, I have acknowledged such work in accordance with accepted scholarly and editorial practice. I give this testimony freely, out of respect for the scholarship of other workers in the field and in the hope that my work, presented here, will earn similar respect.

Ellen H. Paulus
Signature

Oct. 28, 1991
Date

ABSTRACT

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Descriptors: Health Education/ Safety Education/ Nutrition Education/ Mental Health/ Preschool Curriculum/ Preschool Children/ Early Childhood Education/ Parent Education/ Child Development/ Project Head Start

This practicum was designed to increase the ability of staff to incorporate basic health and safety activities, appropriate for preschool children, into the ongoing curriculum of a program which works with children and families in center and home based settings. There were two primary goals: to increase the number of activities offered, and to increase parents' knowledge of appropriate health and safety topics.

The writer developed a curriculum which emphasized health and safety topics. Staff, in both settings, implemented the curriculum. The resulting lesson plans were compared to those developed prior to the introduction of the curriculum. A survey was distributed to parents near the end of the curriculum implementation. The survey solicited information about what the knowledge the parents might have gained as a result of the implementation of the curriculum.

The results of the practicum were favorable. Lesson plans from both settings showed a distinct increase in the number of included activities. The parent surveys in the home based programs demonstrated a modest increase in knowledge. The information gathered from the parent surveys from center based programs was inconclusive.

Chapter 1

Introduction

The setting is a rural preschool program for children aged three to five years. Sparse population density over a large geographic area, including mountains as well as high desert areas, requires program operation in two models. Center based programs have 75 children enrolled and home based programs have 70 children enrolled. The rural character of the program presumes large travel distances: the farthest center is 160 miles away, which is a three and one half hour drive, and the farthest home based program is 180 miles, requiring a four hour drive.

Immediately prior to the writer's hire as education coordinator six years ago, the program had separated from the previous grantee. That grantee, located in a different geographic area, had not acknowledged the needs of the three mountain counties that are the core of the present program. Little understanding of the needs and differences of a dissimilar ethnic and geographic make-up, geographic distances, and hazardous winter driving conditions, which exist from November through March or April, had hindered appropriate supervision.

In 1984, the three mountain counties separated. Adding a previously unserved county, the basis of the present program was developed. Enrollment increased from 55 to 125 children. With little guidance or structure, many staff,

being newly employed, struggled with job responsibilities.

After its first year of operation in 1984, the program was reviewed by the regional office for the funding source. The report documented many areas needing improvement. A major area of concern was curriculum, and the lack of structure and consistency in its content and delivery. The writer has responsibility for these areas needing improvement.

To address areas noted in the regional review as needing improvement, the writer organized the first Education Committee, composed of staff parents, and community members from the education area, in FY 1986. As the program philosophy is to include staff in the development of policies and procedures which will affect them, a focus was curriculum. The initial committee developed a "List of Curriculum Themes", composed of selected themes either REQUIRED to be presented or OPTIONAL, from which staff were to select. Staff were to use only those themes included on the list. Those *not* included were not to be used without receiving prior approval. This provided beginning guidance, but offered too much flexibility.

In subsequent years, the committee narrowed the number of themes and developed some supportive guidance. The development of a program curriculum, based on the program-approved themes and the educational standards of the program

funding source, had begun. However, the differences between curriculum implementation in center and home based models made standardization of a curriculum impossible.

With guidance from staff, parents in the home based program have weekly input in the planning of the curriculum for their child. In centers, parents discuss upcoming themes, and make suggestions, at the parent meeting held in the preceding month. Therefore, a curriculum which offers suggestions for health and safety topics, as well as themes, while allowing for individualization to the needs of the families at each site, would provide a framework for consistency while allowing for flexibility based on the needs at each site.

The committee developed the initial guidance by which the writer monitored the curriculum offered at each site. Center lesson plans (Appendix A:44) were reviewed to determine whether approved curriculum themes were presented. Activities were examined for suitability to the developmental level of the enrolled children. Home based home visit plans (Appendix B:45) were also monitored for presentation of approved curriculum themes. The activities were monitored for parent input, evidence of planning appropriate to the child's developmental level, and reinforcement of the home as a learning environment.

In addition to reviewing the written documentation, the writer visited each center and home based program to observe

firsthand how the themes and curriculum were implemented. Staff received feedback about their performance and the curriculum content. As appropriate, the writer modeled more appropriate ways to present activities.

Chapter 2

STUDY OF THE PROBLEM

Problem Definition

For the purpose of this practicum, the problem was that program staff did not demonstrate an awareness of the interconnectedness of health education, appropriate for preschool children, and a standard preschool curriculum. Although program standards required that health education be included a curriculum "relevant and reflective of the needs of the population served", staff were unable to meet the expectations for curriculum and perform to the appropriate level.

Evidence

Education coordinators, who are in similar settings adjacent to the one in which the writer is employed, met three or more times per year. These meetings offered support and solution options for individual and group problems. The writer approached this group with the curriculum difficulties. Seven of the ten programs represented had experienced the same problem within the employment of the present education coordinator. Three of the seven programs purchased a curriculum. The other four had developed their own curriculum for use in the program. Each program was unique in it its ethnic and geographic make-up. Discussions had been reassuring that a suitable solution to the problem could be achieved. Different programs had experienced

different levels of success with their curriculum. A survey of the coordinators demonstrated that programs which involved staff in the curriculum development had a higher proportion of implementation than those where the decisions were only made on the administrative level. (Table 1)

Table 1

Results of a Survey of Adjacent Programs Having Similar Curriculum Problems by Curriculum Source, Staff Input, and Percentage of Implementation

Program	Curriculum: Purchased	Curriculum: Program Generated	Staff Input: Incl.	Staff Input: not Incl.	%age Used
Sh	X			X	85
Y		X	X		80
B		X	X		75
G	X			X	70
C	X			X	65
T		X		X	55
Y/S		X		X	55
Si	no implementation problems				
ED	no implementation problems				
P/N	no implementation problems				

The lack of health curriculum activities and the interrelatedness of health education to other areas of curriculum had been documented through a variety of channels: reviews by the regional office (Appendices C:46 and D:47) which assess program compliance with the related

Performance Standards (Appendix E:48), program self assessments (Apendices F:49, G:50, H:51 and I:52), onsite observations, and completion of lesson and home visit plans.

Each year, parents at each site conduct a self assessment, with the assistance of management staff. The results determine whether the site is in compliance with program standards. The last four program self assessments determined the program was out compliance in the following areas related to program standards:

1) having a curriculum "relevant and reflective of the needs of the population served"; and
2) including health and safety topics in the curriculum for parents and children (Table 3, page 15).

Many staff were unable to take the themes, determine appropriate health and safety topics for their site, and plan appropriate activities for the enrolled children and families.

The findings of April 1991 review team included a lack of structure and consistency in the delivery of curriculum again "relevant and reflective of the needs of the population served". Also documented was an inadequate implementation of health education in the curriculum.

Along with the lack of a curriculum relevant and reflective of the needs of the population served, onsite observations by the Home Based and Education Coordinators had repeatedly documented omission of basic elements of

early childhood education, especially by newly hired staff. The majority of the expansion had been in the home based model. Staff hiring requirements for home based family educator did not emphasize a background in child development (Table 2, page 14). New staff had greater difficulty implementing appropriate curriculum. Of the seven home based sites, five used unapproved themes. In contrast, only one of three centers used inappropriate themes. Of eleven sites, four included all the required themes during the last program year (Table 3, page 15).

Members of the management team visited each site a minimum of three times per year. Onsites were reviewed verbally at the time, including immediate feedback to the staff. The onsite was also followed up writing after the visit in an onsite report. During the last program year, every site received feedback about the use of inappropriate curriculum, with over half receiving feedback of more health and safety topics needing to be included (Table 3, page 15).

Table 2

Education Level of Teaching Staff
at Time of Employment

	HS diploma	≤ 30 units	≥ 30 units	AA degree	BA/BS degree	MA/MS degree
CENTER STAFF						
Teacher 1			X			
2				X		
3			X			
Asst. T 1**	X					
2		X				
3**		X				
HOME BASED STAFF						
FE 1**	X					
2**	X					
3		X				
4			X			
5**	X					
6		X				
7**		X				

** indicates new staff who were parents in the program

Table 3

Sites and Areas Found to Be Out of Compliance
in Program Self Assessments 1988 through 1991

YEAR	SITE	curriculum does not reflect needs of population served	adequate health & safety topics not included	did not use all REQUIRED themes	used unapproved themes
1988	1C		X	X	X
	3C	X	X		
	4HB	X		X	
	6HB			X	X
	7HB	X			
	8HB	X	X		
	10HB			X	
	11HB		X		
1989	1C		X	X	X
	3C	X	X		
	4HB			X	
	5HB		X		
	7HB	X			X
	8HB	X	X		
	9HB				X
	10HB			X	
	11HB		X	X	
1990	1C		X		
	2C		X		X
	4HB	X			
	6HB				X
	7HB	X			
	8HB	X	X		
	9HB	X			
	10HB			X	X
1991	1C			X	X
	2C		X		
	3C	X			
	4HB	X	X	X	X
	5HB			X	X
	6HB		X		
	7HB	X		X	X
	8HB	X	X	X	X
	9HB		X	X	
	10HB				X
	11HB	X	X	X	

Analysis of Causes

At teacher and family educator clusters, program staff had discussed the curriculum problems. Discussion revealed the desire for a more defined structure, within which each could develop their local site curriculum. Staff wanted to know what was acceptable to include on lesson plans and wanted specific suggestions of what to include. All staff wanted to avoid finding out after-the-fact that what they did was not acceptable.

As many staff were parents in the program before becoming staff members, they were confused as to the role of parents in curriculum development. When their children were enrolled, parents had almost complete control of the curriculum. That was no longer the case. However, wanting to empower parents, staff often relinquished control over the curriculum by allowing parents too many choices with too little guidance. The result had been inappropriate curriculum with plans not meeting program requirements.

Staff in home based programs often had little background in child development, leading to the omission of health and safety topics from a curriculum "relevant and reflective of the needs of the population served".

Each site received onsite visits conducted by various members of the management team, including the Education Coordinator. Each onsite included immediate feedback to the staff. Last year, every site received feedback re. inappropriate curriculum, with over half receiving input

that more health and safety topics need to be presented. Staff members also shared their confusion re. to what extent parents should have input on the curriculum for their child and often allowed parents too many choices, resulting in inappropriate curriculum with plans not meeting program requirements.

In teacher and family educator cluster discussions, staff had expressed being uncomfortable teaching health issues which they might not practice themselves. They were insecure about being a model for children and parents.

The program had emphasized providing employment opportunities to parents. Six present teaching staff had been parents enrolled in the program when parents had more control of the individual curriculum. Staff were confused about who was responsible for curriculum development. As a result, inappropriate curriculum, not meeting program requirements, was used. New staff had been reluctant to ask sufficient questions about educational planning, relying on their limited knowledge and/or experience. The lack of curriculum guidance resulted in poor planning of age and culturally appropriate activities. Families also received less appropriate information when staff had a limited background in child development.

Relationship of Literature

A search of the literature reveals that several authors confirm that there are few resources available for health

curriculum for preschool children. Nelson (1988:360) remarks "There is a lack of public demand and support for preschool health education. Educational resources for early childhood health education also appear limited." "Lack of educational materials, lack of money, and limited community resources were the most frequently cited barriers in rural programs." according to Nelson (1988:362).

Nelson also reported (1988:362-3) "... decisions to adopt health education programs in child care settings can be enhanced by public information and education. Child care directors, parents and the community must come to expect preschool health education as an essential component of a program fostering proper child development, health promotion, and disease control." Hendricks (1984:29) concurs when she states "Health education is a requirement for Head Start; however, no appropriate health education curriculum was available." Nelson (1988:362) also shares that "Results of this assessment suggest health instruction represents an activity in child care programs that is perceived as important, effective, and in need of technical support."

According to David Elkind (1989:114), preschool-aged children need a broad base of experiences from which to learn. It is his opinion that these need to include practical experiences of life. He feels that it is the responsibility of the adult to ensure that the appropriate curriculum be planned. Nelson (1979:13) agrees. A developed

health curriculum included "a framework for the introduction of health education into the classroom and attempted to develop mechanisms for integrating this fully into the Head Start program's full scope of activities." Nelson (1988:362) also found that "More than 95% of the directors perceived health education as an important part of a child care program. ... Nearly all respondents indicated they would use additional educational materials if available."

In his research, Sava (1989:52-54) found that preschool teachers need a firm base in child development to help children make the connection between experiences they have to maximize the learning. Without such training curriculum was often presented in an arbitrary manner, lessening the child's opportunities for learning.

Along the same line, Cheyne (1983:37-40) contends that children must have the opportunity for a diverse variety of play experiences from which to draw their definition of the world. His research discovered that the more training and experience preschool education staff had, prior to being in the classroom with the children, was a predictor of a more diverse and interrelated curriculum. However, it was only a predictor, as the theory did not always hold true. Similarly, Segal (1989:115) contends "Episodes of play ... provide a key stimulant for the maturation of a child ... play advances cognitive development. It encourages a youngster to explore the world around him, learn how things

work, and solve challenging problems."

Marzollo (1989:124) feels that children learn best through active interaction with materials at and in hand. ... "Children acquire many fundamental skills that can have significant consequence for later adjustment." It is her opinion that adults in the child's world have the obligation to determine his interests and plan accordingly. Activities do not have to be excessive, but should be linked, on an ongoing basis, with the events in the world around the child. Nelson (1988:360) asserts "Limitations may be due to ... the assumption that parents of preschool children have sole responsibility for early childhood development and education. Whether or not parents expect health education to be a component of a preschool program remains unclear."

Katz (1989:160) asserts that adults need to present children with a wide variety of experiences which may or may not be related. She feels that children will use the opportunities at hand to extract what they need at that time. Adults need to design an environment in which children have the chance for cooperative play, as "children acquire many fundamental skills that can have significant consequence for later adjustment." Pratt (1987:15) agrees when she says "Young children's knowledge of health and health care may significantly influence their responses to routine health care as well as form the basis for future learning and attitudes toward health."

Bradley (1985:330) states that parents and teachers should consider what they are trying to present to a child. "The world is full of images, information, and stimulation ... try to avoid overloading children with too many projects at one time. The more you can connect activities to one another, the more sense the child will be able to make of his world."

On the converse, David Gilman (1989:47) feels problems can develop if excess stimulation occurs. ... "The environment is so overwhelming. So overwhelming, indeed, that some researchers voice serious doubts over how much change can be brought in multiple-risk children. Brown's Sameroff, who has been dealing with poor, inner-city black and white families ..., says the experience has left him more realistic about what is possible." Gilman (1989:47) also cites Emily Werner, who stated that "at least the high-risk child should be guaranteed basic health and social programs." Nelson (1988:360) agrees when he says "The remainder (the non-handicapped) of Head Start children come from low income households where health needs can be more critical."

"*Not knowing* and *making mistakes* are essential parts of the preschool program. Everyone, especially the teacher, needs to experience mistake making and learning through trial and error with self acceptance and acceptance from others. Sometimes this works and sometimes it doesn't."

Such is the opinion of Heiss (1989:49). While acknowledging the importance of the adult being a model to the children, she also emphasizes that preschool educators do need training to effectively cultivate the development of young children. Otherwise, staff will be unable to maximize the occasions for learning, whether by making mistakes and modeling, or through curriculum planning. Impellizzeri (1979:3) further supports the belief in adults being a model to children when she maintains "We need to provide more action than talking in these years and also be more acutely aware of how young children will read our abilities and actions." John Holt (1989:114) supports the same theory when he says, "Children need to see things done well."

The appropriate background, for staff, in the area of health, is often experiential. Hunter (1988:33), concerned with the increasing prevalence of obesity in America, writes, "Forty percent of the children who are obese at age seven become obese adults." She cites the pioneering efforts, in 1928, of Clara M. Davis, MD which have been reinforced by L. L. Birch, Ph. D. and her associates at the University of Illinois. "Birch suggests that children can determine how much food they require from their own physiological cues." (1988:34)

Davis (1983:4) reports that most states "do not require staff at these (day care) centers to take courses in nutrition education." Hunter (1988:34) talks about Ellen

Satter, R.D., a specialist who treats eating disturbances and disorders, who "recommends that there be a division of feeding responsibilities." The adults "should be responsible for *what* children are offered to eat, and for the physical and emotional setting ... Children should be responsible for *what* is chosen and *how much* is eaten" (1988:34). As the setting and quantity eaten usually reflect the individual's own upbringing, staff should be aware of any variations from the desired focus and take appropriate measures as needed.

Parcel (1984:49) proposes that it is difficult "to determine if a structured health education intervention at age four can influence children's practice of a targeted behavior." He continues (1984:55) "It is our opinion that school-based health education interventions designed to prevent the initiation of a negative health-related behavior ... have significant limitations and will only have an impact on a certain segment of the targeted population. ... Education at school will be only one factor among many that will influence a child's behavior. In fact, other factors within the child's home and larger community environment may be more influential and powerful, thus canceling out the potential impact of school health education."

Elkind (1986:233) sums up how important a quality early child'ood educator is. "Children learn from anything and everything they see. We can best help children learn not by deciding what we think they should learn ... but by making

the world ... accessible to them. In short, what we need to know to help children learn is not obscure, technical, or complicated, and the materials we can use to help them are readily at hand all around us."

Chapter 3

GOALS AND OBJECTIVES

Goals and Objectives

The following goals were projected for the practicum:

1) Over a period of ten weeks, center staff will integrate health education topics into the curriculum at the center by increasing the frequency of the activities to a minimum of two different activities per week for the time period.
2) Over a period of ten weeks, home based staff will integrate health education topics into the home based curriculum by including a minimum of one activity per home and grouping contact for the time period.
3) By the end of the ten week period, staff will demonstrate the use of a thematic approach in the implementation of a health curriculum. Results will be determined by: a) review of lesson plans for inclusion a variety of appropriate activities related to health and safety; and b) comparison of content of lesson plans for this period with lesson plans from the previous program year.

Evaluation Methods

The results of the integration health and safety topics into both the center and home based curriculum was determined by several means.

First, the content of lesson and home visit plans was reviewed and compared with the plans available from the same time period of the previous year. The frequency with which health and safety topics were included was tallied.

Secondly, onsite visits were made to eight of the eleven sites. In that way the writer was able to give immediate critique of the method by which the topics were being included within the theme focus.

Due to the rural nature of the writer's program, every effort was made to ensure ongoing discussion with staff, in person or on the telephone, a minimum of once per week during the duration of the practicum. This was important in terms of being able to brainstorm problems and offer support to staff. This also proved to be the most difficult task to perform due to a busy schedule in and out of the office.

The final method of evaluation was the distribution of a survey to parents. A short survey, to encourage completion by parents, was developed. Distribution was via staff. However, collection of the surveys was more difficult, especially in center programs, as staff often allowed the surveys to go home with the parent for completion.

Chapter 4

SOLUTION STRATEGIES

Information Collection

Kendrick (1988:19) states, "health activities should fit into the natural flow of the program throughout the year". If activities were presented on a regular basis, the parents' understanding of the importance of health and safety would be expanded by involvement. Inclusion of health and safety topics into a curriculum, according to Kendrick (1988:19) "will be more successful if adults are involved in the process and can reinforce the ideas and practices being taught. ... Adults themselves will also gain valuable health and child development information". Impellizzeri (1979:4) concurs when she states "In addition to working directly with young children, education can multiply (the teacher's) impact by working with parents who are, after all, their children's first and most influential teacher. Parent health education can be built in ... by involving parents actively in planning and implementing the children's program." In this practicum, parents were actively involved in the integration of the topics into the curriculum in both center and home based programs. The resulting effects were determined, at the end of the ten week period, through a parent survey.

Rogers (1988:55) supports the concept that "play is a significant force in children's development". Children play

at the level appropriate to their development. In that way, children will interact with curriculum in an age-appropriate manner. As preschool children learn through play experiences, the program staff linked health and safety topics to play activities, such as free play activities, field trips, and dramatic play. Lesson and home visit plans documented what play activities were included. Rogers (1988:56) states that all should be encouraged to play as "we should value play not just for its direct stimulation of cognitive skills and problem solving, but because play is the main feature of what it means to be human".

Health education contains an abundance of science. According to Holt (1977:5), "Science is important", and has traditionally included a wide variety of experiences. He continues, "basic science knowledge about ourselves and the world around us contributes to the development of reasoning and reasonable human beings".

Caballero (1980:22) professes that "young children be encouraged to learn facts and practices that will enable them to make intelligent decisions related to their health. ... Children must be taught these skills at a young age in order that these practices become habits." The research of Nelson (1988:360) agrees as he states "The onset of potentially health-damaging behavior ... frequently occurs at an early age and contributes to a lifetime of ... consequences. Because health-damaging behaviors may be more

difficult to change with increasing age, vigorous educational efforts are needed to prevent or delay the onset of these behaviors among young children. Therefore, health promotion and disease prevention efforts should appropriately include participation by educators in public and private preschool." Hendricks (1988:21) acknowledges that "Health-related learning (knowledge) should be assessed early rather than waiting for the subsequent behavior to be observed. Revision of instruction to facilitate learning could be based on the assessment." By including health and safety topics in the curriculum on a regular basis, staff were able to reinforce, to children and parents, the importance of the health habits and routines.

Harms (1981:15) puts forth the premise that "cooking activities can give children concrete experiences related to other parts of the curriculum, including mathematics, reading, social studies, and oral communication. Cooking clearly promotes learning in many ways." Davis (1983:4) reports the results of a survey which "revealed that nutrition-related activities could be incorporated into five components of the preschool day: group time, art, outside play, lunch/snack, and self-selected activities." This research supports the premise that health and safety issues can be integrated into other parts of the preschool curriculum. Food preparation activities were included daily in centers, and three times per month in home based programs

so as to provide health and safety information to children and parents. Harms (1981:27) continues, "some teachers like to use a theme for the day or week to coordinate their cooking activities with other parts of the curriculum."

As the writer had been dealing with the effects of the problems over a period of time, the Education Coordinator cluster had provided assistance in the examination of the problem. Over half of the ten participating programs have had similar problems in the past. The programs have dealt with those problems either by adoption of a 'purchased' curriculum or by development of their own curriculum. The majority of programs that developed their own curriculum have found a satisfactory solution to their problem. After the writer developed the curriculum, the members of the clusters were asked to evaluate the product and provide input on possible improvements.

Solution Strategy

Having center and home based models within one program created the need for a curriculum, and topics, which could be effectively presented in diverse methods. The first step in the strategy was the development of the annual curriculum, to be used by staff. The health and safety topics were chosen with both center and home based application in mind. To demonstrate the integration of topics in other curriculum areas, activities were scheduled to correlate with community and program observances.

As the enrolled children were developmentally diverse in each option, it was important for staff to plan open-ended activities which the children could execute successfully. Opportunities for socializations with other children occurred less frequently in home based programs. The centers had a greater opportunity to design the learning environment. More chances to have cooperative play, important to Katz (1989), allowed children more chances to develop fundamental skills.

On the other hand, home based programs had more opportunities to present parents with methods to organize daily experiences for learning. Also, centers could more easily provide too many experiences, which could cause the environment to become overwhelming.

It was important to retain the importance of ensuring the curriculum's application in both center and home based. Field staff, as well as coordinating staff in adjacent programs of a similar nature, were solicited for input. The writer attempted to contact each site weekly, giving feedback and receiving feedback on the curriculum's implementation.

Implementation Plan

During the first week of implementation of the practicum, the writer developed an annual curriculum (Appendix J:53) which included a specific list of health and safety topics for staff to integrate into the local

curriculum. The following week, the writer shared the curriculum with the program staff. As the curriculum was a composite of ideas and concerns which staff had previously shared, the curriculum was well accepted. Feedback was noted but no major changes were needed. The curriculum was immediately distributed to staff so that they could begin to make changes in their curriculum planning as needed.

Each week the writer monitored lesson and home visit plans for inclusion of appropriate health and safety topics. Staff were give written and verbal positive feedback within a week of review. Feedback re. concerns and problems was given verbally immediately upon review, and followed up in writing within three days of review.

At the beginning of the fourth week, the writer distributed the curriculum to other education coordinators in the cluster. Written and verbal feedback was requested. The feedback was gathered during the fifth and sixth weeks.

During the sixth week, the writer prepared a survey for parents (Appendix K:54). The surveys were given to parents without delay, and collected in the seventh and eighth weeks of the implementation. Input was evaluated, and the final report was completed for submission.

Practicum Implementation Plan Timeline

Activity	Week									
	1	2	3	4	5	6	7	8	9	10
develop curriculum	- - - - ->									
present curriculum to staff		- - - - - ->								
review lesson plans			- - - - -

Discussion of Action Undertaken

The program in which the writer works had repeatedly discussed the needs of staff for more health and safety topics. The total staff had brainstormed ideas to include in a curriculum. Using that information, plus input from other education coordinators, the writer developed an annual curriculum for program use. Themes related to health and safety, a list of community events, and a specific list of health and safety topics were included. The writer's intention was for the curriculum to be a guide for staff to use when developing the local curricula.

When the final product was shared with the staff, few suggestions for change were made. No major changes were required. The writer distributed the curriculum to staff for immediate use.

From the second to seventh weeks, the writer visited eight of the eleven program sites to observe the implementation of the curriculum and the types of health and safety topics which staff included.

At the end of each week, lesson and home visit plans were reviewed by the writer to monitor the number of health and safety activities included. Verbal feedback was given whenever possible. All feedback was followed up in writing.

The education coordinators, which attend the coordinator cluster, had provided the writer with previous insights and assistance. Four weeks into the implementation,

the writer mailed each a copy of the curriculum for their review. All coordinators sent a favorable response to the curriculum within the timeframe.

The most difficult segment of this practicum was the development of the parent survey. Designed to elicit information on which to evaluate the effectiveness of the curriculum, the survey also needed to be simple to read and to complete. Once completed, copies of the survey were distributed to parents by their local staff person. Staff were available to answer any questions parents might have. Parents were asked to complete the survey immediately. Staff forwarded those surveys which were completed to the writer. The data was evaluated for inclusion in this report.

Follow-on

With the results of the implementation of the annual curriculum in hand, the writer may do the following:

1) later in the year, solicit further parent input re. specific health and safety topics found to be the most beneficial, and *why*;
2) pursue further information on those same topics from the community, so as to develop resources;
3) develop parent handouts, linked to curriculum themes, to use in health and safety trainings for parents; and
4) develop a more comprehensive curriculum for use by early childhood educators.

Chapter 5

Results, Conclusions, and Recommendations

Summary of Findings

The results of the integration health and safety topics into the center curriculum was determined by review and comparison of lesson plan content, onsite visits, discussion with staff, and distribution of a parent survey.

By reviewing the first ten weeks of lesson plans of program years 1990-91 and 1991-92, the effectiveness of the curriculum was determined. A definite increase was noted in the frequency in which health and safety topics were included in the curriculum. The teaching staff in center programs were easily able to integrate the topics into the local curriculum. The frequency of incorporation of related activities increased from an average of two different activities per week to a *minimum* of three. Each site had at least one week in which a different activity occurred each day. Each site had several weeks where at least one day had more than one activity.

Table 4

Number of Health or Safety Activities
Included in Center Curricula
after Implementation of Annual Curriculum

site	3 H/S acts weeks of	4 H/S acts weeks of	5 H/S acts weeks of	>5 weeks
A	1, 6	2, 3, 8	4, 5, 10	7, 9
P	2	1, 3, 6, 7	4, 5, 9, 10	8
Q	2, 7	3, 9	1, 4, 5, 6	8, 10
S	3, 8	1, 5, 10	2, 4, 7, 9	6

Table 5

Total Number of Health and Safety Activities
Offered in Center Programs

	Year = 1990	Year = 1991
Week		
1	..... (13)	..... (16)
2	..... (10)	..... (15)
3	..... (10)	..... (15)
4	..... (8)	..... (20)
5	..... (9)	..... (20)
6	..... (9)	..... (19)
7	..... (8)	..... (19)
8	..... (9)	..... (20)
9	..... (8)	..... (20)
10	..... (6)	.....(21)

Further evidence of the integration of health and safety topics into the center curriculum was revealed through onsite visits and discussion with staff. The writer visited eight of the eleven sites. Staff visited expressed more confidence in the choice of appropriate topics. All eight said that having the curriculum, which specified health and safety topics, helped them feel more secure in making choices. With a variety of possibilities presented, staff were able to choose the topics they saw as most relevant to the chosen curriculum theme.

Additional evidence of the impact of the curriculum topics came from the distribution of a survey to parents (Appendix K:54). Collection of the surveys was more difficult in center programs. However, of the seventy-five surveys distributed, twenty four surveys were collected. In home based programs, fifty two of the seventy surveys were completed and returned.

The results of the integration health and safety topics into the home based curriculum was determined by review and comparison of home visit plan content, onsite visits, discussion with staff, and distribution of a parent survey. Over a period of ten weeks, home based staff were better able to integrate health education topics into their local curricula. This was demonstrated by inclusion of a minimum of one activity per home and grouping contact for the time period.

Table 6

Number of Health or Safety Activities
Included in Home Based Curricula
after Implementation of Annual Curriculum

site	1 H/S act weeks of	2 H/S acts weeks of	3 H/S acts weeks of	>3 weeks
LY	1, 5	2, 4, 8, 10	6, 9	3, 7
G	2, 3, 7	4, 8, 9	1, 6	5, 10
C	1, 4, 8	2, 5, 9	3, 6, 7, 10	8
LL	1, 2, 4	5, 6, 9	3, 10	7, 8
J	2, 4, 9	1, 5, 10	6, 7, 8	3
HD	2, 5	3, 6, 9	1, 7, 8	4, 10
T	1, 4, 5	3, 7, 10	2, 6	8, 9

Table 7

Total Number of Health and Safety Activities
Offered in Home Based Programs

	Year = 1990	Year = 1991
Week		
1	..... (5)	..... (12)
2	..... (8)	..... (12)
3	..... (11)	..... (20)
4	..... (8)	..... (12)
5	..... (7)	..... (13)
6	..... (5)	..... (19)
7	..... (9)	..... (21)
8	..... (8)	..... (23)
9	..... (7)	..... (17)
10	..... (3)	.....(21)

Effectiveness was determined by an increase in the frequency of inclusion of health and safety topics in the curriculum of both center and home based programs, as documented in lesson and home visit plans.

At the end of the ten week period, center and home based staff had demonstrated more effective implementation of a health curriculum, by the themes and activities offered, than in the previous program year. Results were determined by reviewing and comparing lesson and home visit plans for the inclusion of appropriate health and safety activities. (Tables 4, 5, 6, and 7)

The parent survey solicited data about changes, since the beginning of the year, in parents' awareness of health or safety topics. The responses from parents in center programs were inconclusive. Few topics were noted, and none consistently.

In home based programs, seventy percent of the surveys returned noted an increase in awareness of: getting health check-ups; eating healthy foods; fire escape plans; woodstove safety; using a car seat; and calling 9-1-1. more parents commented on what they were learning, rather than what their child had the opportunity to do.

Conclusions

Providing a curriculum with a variety of health and safety topics provided staff with structure and activity ideas. This, in turn, alleviated some fears regarding the

inclusion of health and safety topics in the curriculum.

Parents in home based programs were able to recall more areas in which they, or their child, had had experiences. Those areas were directly related to the health and safety topics included on the curriculum in the earliest part of the year. One might conclude that the emphasis on parent education in the home based model encouraged more awareness on the parent's part.

Recommendations

More health curricula and curriculum materials, appropriate to the preschool years, need to be developed. In addition, further attention needs to be given to assessment of the effect that health and safety education have on the preschool child, and the parent.

With the surge in societal ailments related to unhealthful practices, immediate attention needs to be paid to the education of our young children so that they can avoid the pitfalls which are being placed in front of them. As Nelson (1989:363) states so clearly, "From a public health perspective, to do nothing is no longer an option."

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LESSON PLAN

SITE _____ FROM _____ TO _____ THEME _____

	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
HEALTH/SAFETY				
SOCIAL/EMOTIONAL				
SELF HELP				
LANGUAGE				
PHYSICAL				
COGNITIVE				
INDIVIDUAL GOALS (WHO/WHAT)				

THEME _____ DATE _____ TIME _____ LENGTH _____

Circle One:
Home Visit Cluster Packet

VISIT COMPLETED ____YES ____NO

CHILD _____ WHY NO VISIT _____

OTHERS _____ SNACK _____

ACTIVITIES

SUMMARY: _____

AREAS COVERED FOR CHILD

Social/emotional	
Fine motor	
Gross motor	
Language	
Health/nutrition	
Creative	
Self-help	
Multicultural	
IPP	
Cognitive	
Music/rhythm	
Reading readiness	
Math readiness	

PLANS FOR NEXT HV/CLUSTER

Activity/By Whom Materials Needed

INFO/MATERIALS LEFT (Include: follow-up idea for week, agency business)

****

PARENT(S) _____ **STAFF** _____

****

CONCERNS/COMMENTS _____

Performance Standards /Indicators/Guidance

Appendix C

(C)* (N)

17. The educational aspects of other Head Start components are integrated into the daily education services program. [1304.2-2(d)]

classrooms/home visit sites

#1			#2			#3			#4		
Yes	No	ND	Yes	No	ND	Yes	No	ND	Yes	No	ND
		X			X	X			X		

Interview all component coordinators to determine how the educational aspects of their components are integrated into the education activities. Interview teachers/home visitors and observe activities for examples of integration of components. In the home-based option, health education activities must be integrated into weekly home visits and daily routine of family. Check weekly plans and interview family.

COMMENTS

Lack of health activities beyond daily hygiene routines
Poor integration of nutrition curriculum

REASONS FOR (N)

(C)* (N)

18. There shall be participation in staff and staff-parent conferences and the making of periodic home visits (no less than two) by members of the education staff. (R,I) [1304.2-2(e)(4)]

CENTER-BASED:

A. documentation showing two required "teacher" home visits (FTS sample)
B. parent interviews confirm home visits
C. evidence that staff and parents have jointly developed plans for child and family

IN ADDITION, THE HOME-BASED OPTION PROGRAM:

D. schedule indicating 32 home visits/family/year
E. verification of weekly home visits in records
F. home visitors receive training on techniques and approaches for working with adults
G. number of families per home visitor per week

Yes	No	ND	Yes	No	ND	Yes	No	ND	Yes	No	ND	
X			X			X			X			A
X			X			X			X			B
X			X			X			X			C
									XX			D
									XX			E
									XX			F
									16+16			G

COMMENTS

REASONS FOR (N)

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* Indicates a Performance Standard that has been addressed through indicators

Performance Standards /Indicators/Guidance

classrooms/home visit sites #1 #2 #3 #4

Education 7

The program must be individualized to meet the special needs of children from various populations. [1304.2-2(c)]

(C) (N)

12. There shall be a curriculum that is relevant and reflective of the needs of the population served. (0,I) [1304.2-2(c)(1)]

- A. learning environment reflects the language and culture of the center's enrollment and community
- B. materials reflect cultural, ethnic, gender diversity—dolls, books, records, posters, pictures [see #31]
- C. parents, others invited to share culture [see #15/19]
- D. trips are planned to local events and places representing the cultures of children served
- E. trips to businesses operated by or employing persons of diverse ethnic origins
- F. staff aware of languages of each child
- G. person available who speaks language of each child [see #13/14]
- H. cook/serve foods of populations served
- I. homogeneous ethnic programs promote awareness of different cultures
- J. needs for children with disabilities are addressed

IN ADDITION, FOR THE HOME-BASED PROGRAM OPTION:

- *K. reflection of language, culture, values of family during the home visit*
- *L. parent(s) present and involved during the total visit*
- *M. parent and home visitor jointly plan home visits* [see #15/19]
- *N. home visitor speaks language of family served, or provision is made to assure effective communication*

	#1 Yes	#1 No	#1 ND	#2 Yes	#2 No	#2 ND	#3 Yes	#3 No	#3 ND	#4 Yes	#4 No	#4 ND
A	X			X			X			X		
B		X	X		X		X					X
C			X			X	X			X		
D	X			X					X	X		
E		X				X			X			X
F	X			X			X			X		
G	X				X			X		X		
H	X			X			X			X		
I		X			X		X			X		
J	X			X			X					X
K										X		
L										X		
M										X		
N										X		

Name(s) of curriculum model and curriculum enrichment modules used by the education component.

Locally developed - based on monthly curriculum themes & parent input

COMMENTS

REASONS FOR (N)

Appendix D

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EDUCATION

PERFORMANCE STANDARDS	GUIDANCE
one adult in the center should be available to communicate in the native language.	vide an adult speaking the child's language on a regular basis.
(3) Including parents in curriculum development and having them serve as resource persons (e.g., for bilingual/bicultural activities).	(3) Parents can be valuable resources in planning activities which reflect the children's heritage. Teachers may request suggestions from parents on ways to integrate cultural activities into the program. For example, parents may wish to: • plan holiday celebrations; • prepare foods unique to various cultures; • recommend books, records, or other materials for the classroom; • act as classroom volunteers; • suggest games, songs and art projects which reflect cultural customs.
(d) The education services component of the plan shall provide procedures for on-going observation, recording and evaluation of each child's growth and development for the purpose of planning activities to suit individual needs. It shall provide, also, for integrating the educational aspects of other Head Start components into the daily education services program.	(d) The education plan should specify how Head Start staff will assess the individual developmental/instructional needs of children. Some ways this may be accomplished include: • discussions with parents during recruitment, enrollment, home visits, parent-staff conferences and meetings; • review of child's medical and developmental records; • conferences with medical or psychological consultants where indicated; • teacher observations documenting developmental progress used as guidance in planning for and/or modifying individual children's activities; • use of specific assessment instruments or scales. Planning should take into account the age groups and abilities of the children. For example, activities will differ for three and five year olds. Children with handicaps, like all children, should have specific goals set for them according to their ability. The plan should also include the following: • long-range plans based on evaluation of each child's current needs, interests and abilities; • specific activities and responsibilities of staff members; • consistent methods for observing and recording the progress of each child; • procedures to be used for reviewing each child's progress and modifying the program when indicated.

EDUCATION

PERFORMANCE STANDARDS

GUIDANCE

Activities to integrate educational aspects of other components into the daily education program could include:

- *Health Education* built into the schedule through:
  - time to talk about physical and dental examinations in order to increase understanding and reduce fears.
  - books and pictures about doctors and dentists.
  - materials for dramatic play (stethoscope, nurse's uniform, flashlight).
  - role playing before and after visits to doctors, dentists, hospitals, clinics, etc.

- *Nutrition Education* as part of the daily schedule:
  - assistance in meal preparation, setting table;
  - learning experiences through food preparation (adding liquids to solids, seasoning, freezing, melting, heating, cooling, cooking simple foods)
  - books, pictures, films, trips related to the source of foods, (farm, garden, warehouse, market, grocery store)

(e) The plan shall provide methods for enhancing the knowledge and understanding of both staff and parents of the educational and developmental needs and activities of children in the program. These shall include:

(e) The plan should indicate some of the ways parents and staff will work together to understand each child and provide for his learning experiences. The plan should include details of ways the home and center will attempt to supplement each other in providing positive experiences for the child.

There should be an early orientation to the Education Services Objectives. Special emphasis should be given to the significance of the materials, equipment and experiences provided in a Head Start Child Development program. Interpreters should be available to facilitate full participation of non-English speaking parents.

Procedures should be established to facilitate maximum communication between staff and parents, for example:

- newsletters
- parent/teacher conferences
- group meetings
- phone calls
- home visits
- posters, bulletin boards, radio/TV announcements.

EDUCATION - PROGRAM OPERATIONS

Col. 1	Col.2	Col. 3		Col. 4	Col. 5		Col. 6	Col. 7
Cross Reference Part 1304 Section	Individual Specific Policy	D.A. or Grantee Compliance Yes	D.A. or Grantee Compliance No	D.A. or Grantee Reasons* Code #	ACYF Compliance Yes	ACYF Compliance No	ACYF Reasons* Code #	Guidance for Assessing Compliance
2-2(c)(3)	Including parents in curriculum development and having them serve as resource persons (e.g., for bilingual/bicultural activities)?	X						(3) Interview parents to determine the extent of their involvement in program activities. Home based parents must be involved in planning the content of the weekly home visits.
2-2(d)	Is there on-going observation, recording and evaluation of each child's growth and development for the purpose of planning activities to suit individual needs?	X						(d) Interview education director and selected teachers* to determine procedures for ongoing individual child observation and determination of developmental needs; if specific instruments or scales are used, confirm appropriateness for Head Start population. Determine if information on file about children is free from labeling descriptions and is being used to plan program activities.
	Are the educational aspects of other Head Start components integrated into the daily education services program?		X	2, 40				Interview all component directors to determine how the educational aspects of their components are integrated into the daily education activities. Interview teachers* and observe in classrooms* for example of integration of components. In home based health education activities must be integrated into weekly home visits and daily routine of family. Check weekly plans and interview family.
								*For home-based programs substitute home visitor and home activities for teacher and classroom activities.

*For Columns 4 & 6 please indicate the code number(s) below which best describes the reason(s) for non-compliance.

1.) Insufficient funding available
2.) Insufficient resources available in community
3.) Staff lacks adequate skills/knowledge
4.) (a) Insufficient staffing or (b) Needed consultation
5.) Inadequate parent involvement support service
6.) Inadequate record keeping
7.) Management systems and procedures need improvement
8.) Personnel supervision or motivation needs improvement
9.) Written plan (a) None (b) Incomplete
10.) Other - Please specify on back of page

Appendix II

EDUCATION - PROGRAM OPERATIONS

Col. 1	Col.2	Col. 3		Col. 4	Col. 5		Col. 6	Col. 7
Cross Reference Part 1304 Section	Individual Specific Policy	D.A. or Grantee Compliance Yes	D.A. or Grantee Compliance No	D.A. or Grantee Reasons* Code #	ACYF Compliance Yes	ACYF Compliance No	ACYF Reasons* Code #	Guidance for Assessing Compliance
1304.21(d)(1)(i)	Including parents in curriculum development and having them serve as resource persons (e.g., for bilingual/bicultural activities)?	X						(3) Interview parents to determine the extent of their involvement in program activities. Home based parents must be involved in planning the content of the weekly home visits.
1304.21(d)(1)(ii)	Is there on-going observation, recording and evaluation of each child's growth and development for the purpose of planning activities to suit individual needs?	X						(d) Interview education director and selected teachers* to determine procedures for ongoing individual child observation and determination of developmental needs; if specific instruments or scales are used, confirm appropriateness for Head Start population. Determine if information on file about children is free from labeling descriptions and is being used to plan program activities.
	Are the educational aspects of other Head Start components integrated into the daily education services program?		X	3				Interview all component directors to determine how the educational aspects of their components are integrated into the daily education activities. Interview teachers* and observe in classrooms* for example of integration of components. In home based health education activities must be integrated into weekly home visits and daily routine of family. Check weekly plans and interview family.
								*For home-based programs substitute home visitor and home activities for teacher and classroom activities.

*For Columns 4 & 6 please indicate the code number(s) below which best describes the reason(s) for non-compliance.

1.) Insufficient funding available
2.) Insufficient resources available in community
3.) Staff lacks adequate skills/knowledge
4.) (a) Insufficient staffing or (b) Needed consultation
5.) Inadequate parent involvement support service
6.) Inadequate record keeping
7.) Management systems and procedures need improvement
8.) Personnel supervision or motivation needs improvement
9.) Written plan (a) None (b) Incomplete
10.) Other - Please specify on back of page

EDUCATION - PROGRAM OPERATIONS

Col. 1	Col.2	Col. 3		Col. 4	Col. 5		Col. 6	Col. 7
Cross Reference Part 1304 Section	Individual Specific Policy	D.A. or Grantee Compliance Yes	No	Reasons* Code #	ACYF Compliance Yes	No	Reasons* Code #	Guidance for Assessing Compliance
2-2(c)(1)	Having a curriculum which is relevant and reflective of the needs of the population served (bilingual/bicultural, multicultural, rural, urban, reservation, migrant, etc.)?		X	5				(1) Check classroom materials & activities* to confirm relevance to needs of Head Start population. (Curriculum is the learning environment plus the varied experience provided for participating children.)
(2)	Having staff and program resources reflective of the racial and ethnic population of the children in the program by:							(2) Interview education director, selected teachers* and parents to determine racial and ethnic population served. Check that home visitor speaks the same language as the family served and that program and parent make decision together on the racial/cultural/ethnic match between home visitor and family.
(i) Not applicable to home-based	Including persons who speak the primary language of the children and are knowledgeable about their heritage; and, at a minimum, when a majority of the children speak a language other than English, at least one teacher or aide interacting regularly with the children must speak their language;		X	3				(i) Interview teachers and parents to determine whether or not they speak the primary language of the children and are knowledgeable about their heritage.
(ii)	Having available one adult in the center to communicate in the native language where only a few children, or a single child, speak a language different from the rest		X	2,3				(ii) Interview classroom staff or teacher and identify adults knowledgeable in specific language.

*For home-based programs substitute home visitor and home activities for teacher and classroom activities.

*For Columns 4 & 6 please indicate the code number(s) below which best describes the reason(s) for non-compliance.

1.) Insufficient funding available
2.) Insufficient resources available in community
3.) Staff lacks adequate skills/knowledge
4.) (a) Insufficient staffing or (b) Needed consultation
5.) Inadequate parent involvement support service
6.) Inadequate record keeping
7.) Management systems and procedures need improvement
8.) Personnel supervision or motivation needs improvement
9.) Written plan (a) None (b) Incomplete
10.) Other - Please specify on back of page

Appendix

EDUCATION - PROGRAM OPERATIONS

Col. 1	Col.2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7
Cross Reference Part 1304 Section	Individual Specific Policy	D.A. or Grantee Compliance Yes	D.A. or Grantee Compliance No	D.A. or Grantee Reasons* Code #	ACYF Compliance Yes	ACYF Compliance No	ACYF Reasons* Code #	Guidance for Assessing Compliance
1304.4-2(e)(1)	Having a curriculum which is relevant and reflective of the needs of the population served (bilingual/bicultural, multicultural, rural, urban, reservation, migrant, etc.)?		X	2,3		/		(1) Check classroom materials & activities* to confirm relevance to needs of Head Start population. (Curriculum is the learning environment plus the varied experience provided for participating children.)
(2)	Having staff and program resources reflective of the racial and ethnic population of the children in the program by:							(2) Interview education director, selected teachers* and parents to determine racial and ethnic population served. Check that home visitor speaks the same language as the family served and that program and parent make decision together on the racial/cultural/ethnic match between home visitor and family.
(i) Not applicable to home-based	Including persons who speak the primary language of the children and are knowledgeable about their heritage; and, at a minimum, when a majority of the children speak a language other than English, at least one teacher or aide interacting regularly with the children must speak their language;							(i) Interview teachers and parents to determine whether or not they speak the primary language of the children and are knowledgeable about their heritage.
(ii)	Having available one adult in the center to communicate in the native language where only a few children, or a single child, speak a language different from the rest							(ii) Interview classroom staff or teacher and identify adults knowledgeable in specific language.

*For home-based programs substitute home visitor and home activities for teacher and classroom activities.

Appendix I

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*For Columns 4 & 6 please indicate the code number(s) below which best describes the reason(s) for non-compliance.

1.) Insufficient funding available
2.) Insufficient resources available in community
3.) Staff lacks adequate skills/knowledge
4.) (a) Insufficient staffing or (b) Needed consultation
5.) Inadequate parent involvement support service
6.) Inadequate record keeping
7.) Management systems and procedures need improvement
8.) Personnel supervision or motivation needs improvement
9.) Written plan (a) None (b) Incomplete
10.) Other - Please specify on back of page

ANNUAL CURRICULUM

	EMPHASIS	COMMUNITY HELPERS	EVENTS/ACTIVITIES/FIELD TRIPS	HEALTH/SAFETY	THEMES
SEPT	Season: Fall Color: red Weather: sunny/warm	doctor dentist teacher	doctor/dentist office Rural Hospital Week nature walk walk around center/home	washing hands using toilet, flushing brushing teeth playground safety	Getting Acquainted: names of children/adults where things go, program routine Self Concept
OCT	Season: Fall Colors: yellow, orange Shape: circle Weather: cloudy	librarian farmer firefrighter	Library Card Sign-up Month library pumpkin field/apple orchard fire station Fire Prevent. Wk/Energy Awareness Mo	SAME AS SEPTEMBER scraping off plate health and cleanliness: how and why exercise fire prevention	Self Help- dressing, clearing place taking care of possessions Body Parts Self Concept Fall Local Culture: name
NOV	Season: Fall Colors: brown, black Shape: square	waiter waitress cook	National Children's Book Week Child Safety and Protection Week National Families Week restaurant	different clothes for different weather balanced meals (food groups) child safety	Family Traditions: things you do Family Living: who in it, family growth and changes, roles/responsibilities homes: kinds, what is in each room
DEC	Season: Winter Colors: green, red Shape: triangle Weather: cold	Christmas tree grower store owner city worker	getting the Christmas tree downtown to look at decorations to visit Santa Claus	fire safety wood stove safety treating burns	Family Traditions: My/Your Family Feelings and Emotions: identifying sense of smell
JAN	Season: Winter Colors: white, blue Shapes: rectangle, triangle Weather: snow, fog	grocery clerk salesperson stockperson baker	grocery store bakery Birth Defect Prevention Month	mental health seasonal dress treating simple injuries	Feelings/Emotions: how they sound Winter sense of hearing: soft/loud, rhymes, high/low, what do you hear? animal noises
FEB	Season: Winter Color: pink Shapes: review Weather: stormy, windy	dentist policeman postal worker telephone repairperson banker/ bank teller	Dental Health Month Child Passenger Safety Week post office police station bank	dental health pedestrian safety car seat safety not giving out information on on the phone	Wind and Air Friends sense of taste: taste buds and nose, how foods look alike & taste different, raw/cooked food
MAR	Season: Spring Color: purple Numbers: 0-5	doctor nurse emergency medical technician ambulance driver nutritionist	Children's Hospital Week hospital National Nutrition Month National Poison Prevention Month Drug and Alcohol Awareness Week	good nutrition vs. junk food emergency first aid 9-1-1 safety - poisoning - food	Life Cycles sense of touch - textures our environment - pollution - energy conservation Animals: water/wild
APRIL	Season: Spring Colors: mixing review Numbers: 6-10	librarian gardener forestry worker child care worker	National Library Week nursery Child Abuse Prevention Month Week of the Young Child Earthquake Awareness Month	mental health activities animal safety child assault prevention earthquake drill	Animals - animal babies, zoo, birds - wild, zoo sense of sight: dark/light, Plants: growing food, flowers our environment: recycling/save the trees
MAY	Season: Spring Numbers: 0-10 Weather: warm	truck driver, bus driver rancher, farmer, miner logger, equipment operator teacher, crossing guard school nurse, speech therapist eye doctor, ear doctor	Mental Health Month ranch, farm, mine forest, logging site, mill elementary school Nat'l SightSaving/Transportation Mos. Better Hearing and Speech Month	school bus safety street safety: signs, stop/go mental health seasonal dress ear and eye - safety - protection	On To Kindergarten Local Culture: name Transportation Saying Goodbye Five Senses

October 1991

Dear parents,

I hope you have are enjoying your year so far in Head Start. Please take a minute to answer a few questions about learning experiences you or your child may have had. Feel free to tell us your concerns or ideas. Thank you for your help.

I / We have learned more about (check any that apply):

___ getting health check-ups
___ eating healthy foods
___ taking care of my body
___ that I am important
___ dressing for the weather
___ how to say I am mad
___ exercise is important
___ not putting things in my mouth
___ brushing teeth
___ body parts
___ fire escape plans
___ woodstove safety
___ fire prevention
___ using a car seat
___ washing hands
___ using 9-1-1

Comments/Concerns:_____
_____
_____

October 1991

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I / We have learned more about (check any that apply):

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Comments/Concerns:_____
_____
_____